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# Torts--Battery--Consent and Privilege in Surgical Operations--Tabor v. Scobee

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## Notes and Comments

### TORTS-BATTERY-CONSENT AND PRIVILEGE IN SURGICAL OPERATIONS—TABOR v. SCOBEE

A doctor, performing an appendectomy to which the patient had consented, discovered during the course of the operation that, in addition to acute appendicitis, the patient was also suffering from infected and inflamed Fallopian tubes. The surgeon proceeded to remove the tubes. The patient, a girl of twenty, subsequently sued the surgeon on the ground that he removed her Fallopian tubes without her consent and that she had thereby been rendered sterile<sup>1</sup> and damaged emotionally, physically, and otherwise. At the trial the plaintiff proved that her stepmother was in the hospital at the time of the operation and that no effort was made to procure her consent to the removal of the tubes.<sup>2</sup> On the other hand the doctor's evidence tended to prove that the tubes, being full of pus, severely swollen, and sealed at both ends, were so diseased that the woman was in all probability sterile at the time. Thus the organs were not only dangerously deleterious to the life and health of the patient because they might at any time rupture and cause peritonitis and possibly death, but they were also useless because their functional capacity had been destroyed. The doctor's evidence further indicated that it was proper medical practice in this and similar communities to remove Fallopian tubes in such a diseased condition. Upon conclusion of the evidence the court instructed the jury:

[T]he defendant, Dr. R. H. Scobee, was expressly authorized to operate on the patient, Macine Tabor, for appendicitis; and if the jury believes from the evidence that in the course of such operation that Dr. Scobee discovered that her Fallopian tubes were in a diseased condition and that in his judgment in the exercise of ordinary care and skill as defined in these instructions, such conditions if not removed would have endangered plaintiff's life and health;

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<sup>1</sup> The fact, probably quite startling to the average layman, is that women without either Fallopian tube have given birth to children. "No method of sterilization upon the human female has stood the test of time; at least occasional isolated cases of failure have marred the previously perfect record of each." Dippel, *Tubal Sterilization by the Madlener Method*, SURGERY, GYNECOLOGY AND OBSTETRICS 94 (1940). Also see CROSSEN, DISEASES OF WOMEN 1020 (4th ed. 1947). The writer is personally acquainted with a case where both Fallopian tubes were removed and the doctor informed the woman that she would never have children. A few years later the same doctor delivered a baby for that woman.

<sup>2</sup> The girl, of course, was not of the age of consent and thus could not have given consent even had she been conscious. It was not disputed that the stepmother's consent would have been sufficient.

then Dr. R. H. Scobee was justified in removing the diseased tubes, even though no expressed consent was obtained or given. . . .

The jury returned a verdict for the doctor, and appeal was made by the plaintiff on the ground that the instructions were erroneous in that they allowed the doctor to perform an operation without the knowledge or consent of the patient or anyone authorized to speak for her even though no emergency existed. Upon the foregoing facts the Kentucky Court of Appeals upheld this contention in the recent case of *Tabor v. Scobee*.<sup>3</sup>

### THE LAW

The broad proposition that a surgeon who performs an operation without his patient's consent is liable for a battery is well settled.<sup>4</sup> Contrariwise it is certain that when the surgeon is faced with an emergency and failure to operate without delay will prove imminently fatal or seriously detrimental to the health of the patient and consent is not practicably procurable, he will not be liable for performing the operation even though he has made an honest error in judgment as to the proper course to pursue in the emergency.<sup>5</sup> In such an emergency situation the doctor may be considered as privileged.<sup>6</sup>

A landmark case applying in all its rigor the rule requiring consent to a surgical operation is that of *Mohr v. Williams*.<sup>7</sup> In this case the patient had consulted the doctor in regard to a difficulty in her right ear. The ear was examined and an operation advised, to which the patient consented. When the patient was under anesthetic, the doctor discovered in her left ear a condition even more serious and demanding of surgery than the one in her right ear. He operated on her left ear. She sued for assault and battery and recovered. On appeal the Oklahoma court affirmed. The court said that if the physician in the course of an operation to which the patient has consented discovers conditions not anticipated prior to the operation and which, if not removed, will endanger the life and health of the patient, he will be justified in *extending* the operation to remove and overcome them though no consent be given.<sup>8</sup> However, after stating this "rule", the court said that this was not such a case, that the diseased condition of the plaintiff's

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<sup>3</sup> 254 S.W. 2d 474 (Ky. 1952).

<sup>4</sup> *Wall v. Brim*, 138 F. 2d 478 (5th Cir. 1943); *Valdez v. Percy*, 35 Cal. App. 2d 485, 96 P. 2d 142 (1939); *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905).

<sup>5</sup> *Jackovach v. Yocom*, 212 Iowa 914, 237 N.W. 444 (1931); *Luka v. Lowrie*, 171 Mich. 122, 136 N.W. 1106 (1912).

<sup>6</sup> *PROSSER ON TORTS* 120 (1941).

<sup>7</sup> 95 Minn. 261, 104 N.W. 12 (1905).

<sup>8</sup> *Ibid.*, 104 N.W. at 15.

left ear was not discovered in the course of an authorized operation on the right, but upon an independent examination of that organ made after the authorized operation was begun. Thus the court would distinguish between an "independent" operation, as in the case it had before it, and an "extended" operation, as it would probably designate the operation in the *Scobee* case. Is such a distinction sound? It is submitted that there is no fundamental legal difference between the situations in so far as the necessity for consent is concerned, and the same principle upon which the requirement of consent is based in the one case supports the requirement in the other.<sup>9</sup> However, the difference between a fact situation constituting an "extended" operation and one constituting an "independent" operation may be important where privilege is involved, as will appear subsequently herein.

The "rule" for cases of "extended" operations suggested by way of dictum in the *Mohr* case was later repeated in the case of *King v. Carney*<sup>10</sup> in an apparent attempt to relieve the rigor of the rule requiring consent. In the *Carney* case the plaintiff contended that her directions to the doctor prior to the operation were so limited that he was only authorized to perform a laceration of the uterus; he in fact removed her Fallopian tubes. Though the dictum of the *Mohr* case was approved in this case, which the court apparently considered an appropriate case for the rule, the court did not need to invoke the rule. The narrow holding was that, as a matter of construction, the patient's directions impliedly authorized the doctor to diagnose her case and perform whatever operation he might deem necessary after making an exploratory incision. The implied consent found by the court in the *Carney* case was a *real* consent, i.e., it was actually understood though not expressly stated that the surgeon should do all that he deemed necessary to effect the cure.

All the surgical cases use the implied consent terminology. However, whether it is used to mean that there is actual consent implied though not expressly given as in the *Carney* case, or whether it is used to mean that there is such an emergency that consent will be implied though none be given, or whether it is used to cover a situation in between that of actual consent implied and that of consent implied from an emergency is often difficult to tell.<sup>11</sup> In the last situation, as

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<sup>9</sup> *Wall v. Brim*, 138 F. 2d 478 (5th Cir. 1943).

<sup>10</sup> 85 Okla. 62, 204 P. 270 (1922).

<sup>11</sup> See *Barnett v. Bachrach*, 34 A. 2d 626 (1943); *Paulsen v. Gunderson*, 218 Wis. 578, 260 N.W. 448 (1935); *Jackovich v. Yocum*, 212 Iowa 914, 237 N.W. 444 (1931); *Wells v. Van Nort*, 100 Ohio St. 101, 125 N.E. 910 (1919); *Luka v. Lowrie*, 171 Mich. 122, 136 N.W. 1106 (1912).

in the case of emergency privilege, there is, of course, no consent whatever; any consent implied is purely fictional.

The promiscuous use of the term "implied consent" has not only resulted in ambiguity in the cases but has also left a definite gap in the law. Express consent, actual consent implied, emergency privilege—all of these are clearly defenses to an action against the doctor. But it is earnestly submitted that there is an area where there is no actual consent, express or implied, nor is there a strict emergency, and yet wherein the doctor should not be liable for performing a surgical operation. As previously indicated, many courts may have envisioned this area when they referred to the defense of implied consent. If so, then certainly guide posts into the area should be supplied, for it is, of course, absence of definition which raises the question whether the courts have recognized any such area at all.

The proposition that a doctor should not be liable for performing a surgical operation in some situations though there be no actual consent, express or implied, and no emergency, seems to be supported with some degree of clarity by only one case, that of *Bennan v. Parsonnet*.<sup>12</sup> The singular lucidity of the court's opinion in that case merits the somewhat detailed discussion of it that follows.

The plaintiff was an indigent man for whom defendant had gratuitously agreed to repair a rupture on the left side. After the operation had commenced, the doctor discovered a very serious and dangerous rupture on the right side, and this he repaired. The trial court charged the jury that the operation was a legal wrong unless consented to but that consent might be inferred and that it should be inferred if the condition discovered endangered the plaintiff's life or health. On appeal from a judgment for the plaintiff it was held that these instructions substantially embodied the common law rule (*Quere*: Was the common law rule so broad?) but that this rule had been modified by the introduction of anesthesia into the practice of surgery. Admittedly the patient must be the final arbiter of whether he shall undergo the operation or chance living without it, but under anesthesia the patient cannot consent at the very time the common law required his consent, for in the early days of surgery the patient was a conscious participant in the surgical operation, and as his consent could be obtained, the rule of the common law was that it must be obtained. Anesthesia has not only rendered consent during the operation unattainable, it has made of everyday occurrence surgical operations of a character and magnitude not dreamed of at the time the common law was in the mak-

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<sup>12</sup> 83 N. J. L. 20, 83 Atl. 948 (1912).

ing and has postponed the complete and final diagnosis formerly made at a time when the patient could be both informed and consulted. Then the court says:

By these considerations the scope of modern surgical operations has been greatly enlarged, and *the legal rule applicable thereto extended beyond the emergencies of actual surgery to other matters more or less vitally affecting the patient's welfare.*<sup>13</sup> [Writer's italics]

Then the court lays down the rule that where a person has selected a surgeon to operate upon him and has appointed no other person to represent him during the period of unconsciousness, the law will by implication constitute such surgeon the representative of his patient, and will within the scope of the implication cast upon him the responsibility of so acting in the interest of his patient that the latter shall receive the full benefit of that professional judgment and skill to which he is legally entitled. Such implication, says the court, does not license the surgeon to perform an operation different from that consented to or one involving risks and results of a kind not contemplated; but the surgeon, as the implied representative of his patient, can truly represent him only in so far as he gives to him the benefit of his professional wisdom within the general lines of the curative treatment agreed upon between them.

*Within such general lines, however, much is necessarily left to the good judgment of the operating surgeon, just how much will depend upon the circumstances of the individual case.*<sup>14</sup> [Writer's italics]

In applying these principles to the case before it, the court said that a ruling that the operation performed was different from the one consented to would be based upon too narrow a view. The plaintiff had sought correction of a rupture and he is thus presumed to have contemplated all risks incident to an operation for such a condition. Whether the operation is performed on the right or left side, its dangers are the same. If the patient had known that at the same risk and with the same absence of expense he could be relieved of a condition seriously threatening his life and health, *it is inconceivable that he would not have assented to the operation.* Under such circumstances the operation is in no true sense against the will of the patient nor in a legal sense different in kind from that consented to. The court concluded:

This concluding suggestion may perhaps be ethical rather than legal, but it does seem that in good morals a patient ought not,

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<sup>13</sup> *Ibid.*, 83 Atl. at 950.

<sup>14</sup> *Ibid.*

in his efforts to obtain a money verdict, be permitted to repudiate the sound judgment exercised in his behalf by the surgeon of his choice in whose judgment, had he been capable of being consulted, he would unquestionably have concurred.<sup>15</sup>

It is readily perceived that *Bennan v. Parsonnet* recognizes non-liability where the doctor operates without real consent, express or implied, and in the absence of an emergency. But this exceptional non-liability as developed in the case exists only in the narrow fact situation where the patient has submitted to an operation and has appointed no one to represent him. Although a commendable departure from existing law, the *Bennan* case is yet too narrow to satisfy the exigencies of Twentieth Century medical practice.

The same sound policy considerations underlying the decision help support, however, the broader rule here proposed. This broader rule recognizes non-liability in cases beyond the scope of the *Bennan* case although the doctor is not attired in the robe of actual consent, express or implied, or emergency privilege.

In the modern practice of medicine the operating physician, exercising his skill and judgment in behalf of one who has committed his case unto him, should not be placed in the serious and constant dilemma of deciding at his absolute peril whether that which he thinks should be done is within the express or implied consent of the patient, and if not, if it is required by an emergency—decisions which may of themselves be mountainous but which if wrongly made may conclusively impose liability upon the doctor if he does not delay the operation long enough to consult with one capable of consenting. In such cases the doctor should be clothed with a privilege of law based upon a sound public policy adapted to the modern practice of surgery. The area in which such a privilege exists might well be denominated "probable consent", for it should exist only where it appears that the patient would have consented had he been consulted. Admittedly the probable consent is no consent, a pure fiction, just as is the consent which is sometimes implied in an emergency. But just as the law clothes the doctor with privilege in case of an emergency, it should clothe him with privilege in a case of probable consent, the doctor having the burden of proving the probable consent as a matter of defense.

The implied representation concept of the *Bennan* case is thus replaced by the broader concept of probable consent. However, the factors gathered from the New Jersey Court's opinion in this case defining the bounds of implied representation are used in ascertaining the

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<sup>15</sup> *Ibid.*, 83 Atl. at 951.

existence of probable consent, as will appear subsequently. Thus, not only from the standpoint of policy considerations but also from the standpoint of the criteria used in determining whether a particular case is an exception to the general rule, the *Bennan* case at least paves the way for the suggested rule.<sup>16</sup>

#### THE PROPOSED RULE

An operation cannot be performed without the patient's consent unless the physician is privileged.

Consent may be either express or implied. Express consent has its obvious meaning—consent to the particular operation expressly given to the doctor.

By implied consent is meant not a fictional, non-existing consent, but a consent to the operation no less real than express consent. Implied consent exists where it is understood, though not expressly stated, that the doctor shall do whatever he deems necessary to effect the cure. Whether there is such an understanding is a question for the jury.

Privilege may exist in either of two cases. First, in the case of an emergency, i.e., where the patient's condition is critical and the doctor must act without delay in order to save the patient from death or serious impairment to health. This situation includes not only an ordinary accident case where one might be unconscious and bleeding to death, but also a case where the patient is under anesthetic and the doctor discovers a condition which will result in practically *certain* death or serious bodily harm if the doctor does not act *now*, either because failure to act now will necessitate another operation in the near future and it is probable that the patient cannot survive the future operation without death or serious bodily harm, or because the condition will probably deal its damaging blow without warning in the near future. In determining emergency, the emphasis is placed upon *certainty* of, not *time* of, death or serious bodily harm, although the time would necessarily be fairly proximate. In passing it might be noted that there has been somewhat of a gap in the law at this point resulting from an inadequate definition of emergency, the courts apparently having emphasized the time, not the certainty of death, if the doctor fails to act. As will subsequently appear, the Kentucky court in the *Scobee* case was at least approaching the proper emphasis in instructing that the unauthorized operation might be justified if a subsequent operation would unduly endanger the patient's life.

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<sup>16</sup> Also see *Barnett v. Bachrach*, 34 A. 2d 626 (D. C.—1943).



Observe that the rule here submitted imposes no condition upon the doctor's privilege to meet the demands of an emergency in order to save an unconscious patient. There is no suggestion that he can operate *only if* consent is not practicably procurable. Suppose the following: A fifteen year old boy is bleeding to death. An operation without delay is his only salvation. The doctor and the father stand on either side of the dying boy. The doctor says: "I must operate." The father replies: "No, I do not believe in surgery." A bystander rushes to the nearby courthouse and gets from the judge an order to the sheriff to protect the doctor in performing the operation. The sheriff hastens to the scene; the doctor operates; the boy recovers. It is believed that the doctor could not be guilty even of a technical assault. Surely an overriding public policy would not allow a parent to deny consent where the child is in a state of strict emergency. It must be admitted here that the proposition that a parent could not deny consent in the case of a strict emergency has never been recognized by any court. In fact, the emergency cases always consider the impracticability of procuring consent, thus implying the possibility that it could be legally denied. But if a court is ever faced with the question, it is believed that it will reach the result here submitted.

Second, privilege exists where there is probable consent, i.e., where the patient has been placed under anesthetic for an operation to which he has consented, and while under anesthetic the doctor discovers a condition, the removal of which will require an "extended" or even "different" operation, and to the removal of which the patient would probably consent at that time and by that doctor if he were consulted. Whether such a situation exists is a question for the jury to determine from the circumstances of the particular case.

It may be objected that this rule leaves the patient at the mercy of the doctor's caprice. Not so. A jury may well believe that the patient would not have consented to the operation performed at that moment, that the organ removed was of such a nature that, had he been consulted, he would have desired to weigh the matter further, possibly by securing other medical advice, before consenting to its removal. Or a patient may convince a jury that, had he been informed of the type of operation needed, he would have wanted some other surgeon, possibly a specialist, to do the work.

On the other hand it may be argued that this doctrine of probable consent places an intolerable burden upon the operating physician in requiring him to prove the highly subjective proposition that the patient would have consented had he been consulted. It should not be forgotten that probable consent covers only the situation where

there is no consent, express or implied, and no emergency, a situation where in the present state of the law the doctor is conclusively liable, and a situation in which, if the doctor operates, he ought to be required (and at the same time, allowed) to show that the patient would have consented. The doctor may convince the jury that he had been the trusted family doctor for two generations, that the patient had always relied exclusively upon his medical advice, and that, had the patient been consulted, consent would have unquestionably been granted. These suppositions are injected only to show that the rule is a rule, albeit highly subjective.

The importance of the jury here cannot be over emphasized, and this body should consider factors such as the following:

1. The urgency of the situation. Great urgency, of course, would constitute emergency. But when the urgency is something less, then the degree of urgency in relation to other factors here listed is an important consideration in determining the existence of probable consent.
2. The type of relief or treatment originally sought. Was the operation which was actually performed the one needed by the patient to relieve him of the condition which originally prompted him to seek medical aid? Or was that which was done completely unrelated to the cause of the patient's original complaints? (At least this one factor probably existed in the *Scobee* case; i.e., the infected tubes contributed to the abdominal pains prompting plaintiff's solicitation of medical aid.)
3. The similarity between the operation performed and the one consented to. Was the operation performed the same type operation consented to except on a different side? (The *Bennan* case.) Or was the performed operation wholly unlike the one consented to? (Plaintiff submits to an appendectomy and awakens with an amputated leg.)
4. The risks contemplated in the operation consented to, and the risks involved in the operation performed. Was the operation consented to only a minor operation with little danger involved, while that performed was a very dangerous and delicate operation?
5. The results of the operation performed as compared with those originally contemplated. (The importance of this factor is seen in the *Scobee* case: An expected loss of an appendix weighed against the loss of probability of motherhood.)
6. The relationship of the physician and patient. Had the physician been the patient's exclusive medical counselor through the years, or otherwise?
7. The patient's financial condition. Reconsider the *Bennan* case. Failure to mend the patient's right rupture probably would not have been fatal within a few moments after its discovery. Perhaps it could have been corrected the following week without much more physical damage being caused by the delay. But had the doctor not rectified the ominous condition, it would have unleashed its destructive potential in the near future; however, at this future time the charity patient may have found himself without adequate medical care and in a position peculiar to poverty

where, although gratuitous service would somewhere be available, it would not be procured. It is submitted that this patient's case would more readily be a case of probable consent than would the case of Henry Ford, Jr., in otherwise similar circumstances. (It is not intimated that a doctor shall have freer reign with an indigent patient because the law is less protective of the rights of such a person, but merely that poverty may combine with other factors to constitute a case of probable consent.)

8. Has the doctor made an incision which will have to be reopened in the future if the deleterious condition discovered is not now removed? The question indicates that it may be an important factor whether the case is one of an "extended" operation or of a "different" operation, the former more readily being a case of probable consent.

This list of considerations to be made by the jury is not intended to be complete, as other factors will arise in other cases. It primarily reflects the considerations suggested by the cases dealt with herein. Nor is it intended that this list shall apply in its entirety to all cases. But the appropriate considerations should be included by the court in its charge to the jury in each case, the language being adapted to the facts of the case.

#### THE SCOBEE CASE

It is submitted that the decision of the Kentucky Court of Appeals reversing the judgment of the trial court in the *Scobee* case was correct. The opinion of the Court of Appeals stated that the instructions of the trial court were erroneous for at least three reasons. (1) They authorized the removal of the tubes without considering whether it was practicable for the surgeon to obtain the stepmother's consent. (2) They did not impress upon the jury that the emergency must exist at the time of the operation; rather the jury could reasonably infer that the diseased tubes would only have to endanger the patient's health or life sometime in the future. (3) The instructions injected into the case the negligence concept of ordinary care and skill when the action did not involve either the professional judgment or surgical skill of the physician, thus differing from the usual malpractice action.

The court prescribed the following instruction in the event of another trial:

The court instructs the jury that Dr. Scobee was expressly authorized to operate on the plaintiff, Macine Tabor, for appendicitis, but that he was not expressly authorized to remove her Fallopian tubes and you shall find for the plaintiff, Macine Tabor, for the unauthorized removal of her Fallopian tubes under Instruction 'B'<sup>17</sup> unless you believe from the evidence that their condition was such that it would have endangered her life to have let them stay in either because they might immediately have ruptured or because a separate or later operation for their removal might unduly have en-

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<sup>17</sup> Instruction B related to damages.

dangered her life or her health and it was impracticable at the time for Dr. Scobee to obtain the consent of either Macine Tabor or her stepmother, Mrs. Tabor, before the removal of the tubes, in which event you will find for the defendant, Dr. Scobee.<sup>18</sup> (Writer's footnote 17.)

Manifestly these instructions are a grand step in the right direction by the Kentucky Court, and they define the position of this court with far more exactitude than is found in the opinions of other courts. The instructions, however, may be criticized in two respects.

First, under these instructions even if there was a strict emergency the doctor could not operate without the stepmother's consent if such could be practicably procured. It is vigorously urged that no consent or no effort to obtain consent should be necessary in the case of strict emergency even if the stepmother were standing right beside the doctor. This is but another way of saying that, for reasons previously stated, the stepmother could not lawfully deny consent in such a case, although admittedly no cases in point have been found.

A second criticism is found in the court's reference to a later operation "unduly" endangering the patient's life or health. The court may mean that a later operation, a later reopening of the plaintiff's abdomen, will *probably* cause death or serious bodily harm. If this is what the court means by undue danger, then it is earnestly urged that the doctor, faced with a situation where his failure to act now will unduly endanger the patient's life or his health, is faced with a strict emergency in the same sense and as surely as where failure to act will result in immediate death or immediate serious bodily harm. In this situation it would surely be the *certainty* of death or serious bodily harm by failure to act now, not the *time* of death or serious bodily harm, that would determine the existence of an emergency. Again, no consent and no effort to obtain consent would be necessary. (It should be noted here that the instruction makes no provision for the possibility that, if the doctor does not act now, the tubes will burst without warning and cause death or serious bodily harm in the near future, this situation also being one of real emergency, as previously indicated, and one which should be covered by the instructions.)

However, when the court speaks of a later operation "unduly" endangering the patient's life or health, it may mean something less than the situation of emergency described above. It may mean that the future operation would be serious, that there would be some possibility—far short of probability—that the future operation would cause death or serious bodily harm, but a great probability that it would

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<sup>18</sup> Tabor v. Scobee, 254 S.W. 2d 474 (Ky. 1952).

not. If this is what the court means by undue danger, then it is submitted that the doctor could not have legally operated on the patient regardless of how impracticably procurable was the stepmother's consent unless the situation was one of probable consent, for this would be the very type of situation in which the patient or one standing in loco parentis would have the right to determine whether she should chance living without the operation. But under the court's instructions with this meaning ascribed to the "undue danger" phraseology, the doctor might legally operate when he should not be allowed to operate unless there is probable consent.

At this point a very serious question might be raised. Conceding the soundness of the proposed doctrine of probable consent, would the doctrine be applicable to a case involving a minor, such as the *Scobee* case? A reason for the policy of the *Bennan* case, upon which the doctrine of probable consent is largely based, was that the patient was under anesthetic and could not consent. Therefore, where the patient is a minor and the consent of a parent or one standing in loco parentis can be practicably procured, one of the reasons for the rule no longer exists. (Obviously if such consent could not be practicably procured, the same reasons invoking the probable consent rule in other cases would exist.) As previously indicated, it is not intended that the rule of probable consent be limited only to cases where consent cannot be procured, but that the doctor, who has given the patient the benefit of his best skill and judgment be allowed in any case to set up as a defense that the patient would have consented had he been consulted. Operations must go on. Doctors can scarcely pause in the middle of surgery to go on a fishing expedition to find consent for that which they honestly believe should be done. It is reiterated that the burden of proof is on the doctor. Thus for his own safety the doctor will find it highly desirable to obtain consent; nevertheless, if in the exercise of honest judgment he proceeds without consent, he will not be conclusively liable.

It is believed that the rule proposed in this note is the only one that contains the correct concepts for a case such as the *Scobee* case, and that these principles should be presented in full to the jury as concisely as possible, though admittedly the tersest charge may be somewhat lengthy. If under such instructions the jury should find in a case like the *Scobee* case no actual consent, express or implied, and no emergency (and it is not suggested that it could not find an emergency), then it could well be that one consideration alone would convince the jury that there was also no probable consent as defined in the instructions, viz., that a woman who had expressly consented to a

removal of her appendix awakened from anesthesia to discover the horrible fact that her Fallopian tubes were gone. With this fact before it, the jury might believe that, had the woman's stepmother been consulted, she would not have consented to the removal of the Fallopian tubes *at that time by that doctor*, that she would have desired further medical consultation, possibly with a specialist, before accepting the fact that the tubes could not be saved. Certainly probable consent would be difficult to prove in a case like this. Still the doctor is entitled to the instruction, as he would be in a closer case, such as the *Bennan* case.

#### RECAPITULATION

The primary purpose of this note has been to emphasize the need for a new and defined area in the surgical operations cases, that area being here denominated "probable consent." However, two other important proposals are incidentally made. First, that the courts should define emergency cases so as to emphasize the certainty and not the time of death or serious bodily harm should the doctor fail to operate. Second, that the courts no longer imply that consent of a parent is necessary before operating on a child in a case of strict emergency if it is practicably procurable, it being unjust to suggest that consent could be denied in such a case.

The reader may have inferred that the whole purpose and effect of this note is to give the doctor greater immunity from liability when he decides to swing his scalpel. On the contrary, the writer feels that the surgeon is notoriously able to bear any financial loss which he might suffer by reason of the present rule. However, the patients would be the ultimate beneficiaries of the rules here advanced, for under these rules they are more nearly assured of maximum surgical skill.

WILLIAM A. RICE

#### CONTRACTS—FORBEARANCE OF SUIT AS SUFFICIENT CONSIDERATION

Consideration as a requisite for the enforceability of a promise<sup>1</sup> requires a detriment incurred by the promisee, or a benefit received by the promisor which has been bargained for as the agreed exchange.<sup>2</sup>

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<sup>1</sup> GRISMORE, PRINCIPLES OF THE LAW OF CONTRACTS, 81 (1947; Note, 26 HARV. L. REV. 429 (1913)).

<sup>2</sup> 1 WILLISTON & THOMPSON, WILLISTON ON CONTRACTS 323, (rev. ed. 1936).